CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2011 FORM APPROVED OMB NO. 0938-0391

l	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155221		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPL 05/31/2	LETED
	PROVIDER OR SUPPLIER		STREET A 1120 EA	ADDRESS, CITY, STATE, ZIP CODE AST DAVIS DRIVE HAUTE, IN47802	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	E	(X5) COMPLETION DATE
F0000	State Licensure S Survey dates: Ma Facility number: Provider number AIM number: 10 Survey team: Teresa Buske RN Mary Weyls RN Laura Brashear F Census bed type: SNF/NF: 62 Residential: 34 Total: 96 Census payor typ Medicare: 12 Medicaid: 26 Other: 58 Total: 96 Sample: 15 Residential samp Supplemental sam These deficiencie findings cited in 16.2.	ny 23-27; and 31, 2011 000126 : 155221 0266400 I -TC RN	F0000	By submitting this docume are not admitting the truth accuracy of any specific fir or allegations. This submit made solely pursuant to our regulatory obligations.	or Idings Ission is	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JU3511

Facility ID:

000126

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155221		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/31/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER		P. "III	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
DAVIS G	ARDENS HEALTH (CENTER		1	AST DAVIS DRIVE HAUTE, IN47802		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	Quality review co	-					
F0225 SS=E	have been found gor mistreating reside have had a finding nurse aide registry mistreatment of resoftheir property; a has of actions by a employee, which we service as a nurse the State nurse aid authorities. The facility must eviolations involving abuse, including in and misappropriating reported immediate the facility and to with State law throe (including to the Stagency). The facility must he alleged violations and must prevent the investigation is the investigation is the reported to the addrepresentative and accordance with State survey and covering days of the working days of the side of the side of the survey and covering days of the side of the sid	nvestigations must be ministrator or his designated it to other officials in state law (including to the certification agency) within 5 e incident, and if the alleged appropriate corrective					

JU3511

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155221 05/31/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1120 EAST DAVIS DRIVE DAVIS GARDENS HEALTH CENTER TERRE HAUTE, IN47802 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Based on interview and record review, the F0225 What corrective action(s) will be 06/29/2011 accomplished for those residents facility failed to report to the found to have been been affected Administrator and DON immediately and by the deficient practice:Resident thoroughly investigate allegations of #65 is no longer at the facility. Residents #3, 48, 42, and 5 have mistreatment for 5 of 15 residents had no further incidents. CNAs reviewed in a sample of 15. [Residents #3 and #14 are no longer #63, #3, #5, #48, #42] employed at the facility. The private sitter for #48 no longer Findings include: cares for the resident. LPN #19 was suspended for investigation of allegation of abuse on 1. On 5/26/11 at 12:20 p.m. the facility's 5/27/2011. Investigation included compliance/grievance log was reviewed. interviewing resident #42, A form titled "Report of Grievance or interviewing other residents, interviewing coworkers, and Complaint," with received date of 11/8/10 notifying the Indiana Department was noted of "Name of person making of Health. Based on the complaint [name] [Resident #63] with the investigation outcome the following documentation: "Concern employee returned to work; the resident and the Indiana report to Social Services staff- [names] Department of Health were Name and title of person completing notified of the outcome. How other report [name] SW." The description of residents having the potential to concern was noted of: "States that CNA be affected by the same deficient practice will be identified and on nights [CNA #14] made her feel like what corrective action(s) will be she was too much trouble, was distant and taken:All residents have the noncaring when she came in to provide potential to be effected by this care-states that told her when answering a deficient practice. All staff will be educated on the community's light that I can put you on the bedpan-but policy and procedure associated I have to go to lunch-left call unattended with abuse/allegations of abuse long periods of time (1 hour) would have identification and timely reporting to wet the bed. Witnessed by [names of with emphasis on: the need to report to the supervisor, DON and social service and leisure service the administrator with nights, workers."] An additional note on the weekends or holidays not being form included "Res [resident] was tearful an exception; the need for the during interview when began thinking of accused individual to be removed from the community the CNA. Stated she "tensed up" before

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		A (X2)				URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A F	BUILDING	00	COMPLE	ETED
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NAME OF	PROVIDER OR SUPPLIEI	R		I	ST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH	CENTER			HAUTE, IN47802		
						-	07.5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		NCY MUST BE PERCEDED BY FU R LSC IDENTIFYING INFORMAT		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	COMPLETION DATE
IAG	ŧ	CLSC IDENTIFTING INFORMAL	ION)	IAG	immediately; thorough		DATE
	CNA came in."				investigation of the situation	with	
					documented interviews with		
Documentation on a copy of the Report of			of		staff (on all shifts) who have		
Grievance or Complaint form indicated					contact with the resident duri		
	the complaint wa	as reported to the forme	r		the alleged event; notification		
	_) for follow up. The			the responsible party and MI) in a	
		cluded interview of CNA	(timely manner; and,		
	1		I .		abuse/allegations of abuse b	у	
		14. The written statemen	11		visitors, family members, or	-l	
		included, but was not			anyone in contact with a resi mandates the same reporting		
		w days after the resident			requirements and follow up a		
	room [number]	was admitted she started	l		with community employees.		
	asking me what	was wrong with the CN	A		staff will be educated on the		
	on night shift	she stated that the CNA			grievance/concern policy and	d	
	_	hy and acted like she wa	I .		procedure with need for follo	w up	
		ut something. The			in a timely manner. The Soc		
	1 -	•			Service Director will bring an		
		rted to act nervous and			new complaints to daily stand		
		I would put a brief on he	I		meeting and will work, along	with	
	I asked the resid	ent why she wanted it o	n		the administrator and other management, to immediately	,	
	if she uses the be	edpan throughout the			identify and act on any comp		
	night. The resid	ent then stated that she			that may involve abuse or	nainto	
	tries to use the b	edpan but the CNA [#14	41		possible abuse. The commu	ınity	
		answer her call light, it	·		will provide information to the		
	_	er wetting the bed. The			residents of the recommende		
		-			home health agencies when		
		ed upset while talking			resident is in need of or design		
		on saying that the CNA			private duty assistance. If the		
		at her when she has to			resident or their responsible chooses not to utilize a	party	
		The resident kept askin	-		recommended agency then t	the	
	me why the CNA	A [#14] was treating her			resident will be provided with		
	that way. The n	ext day, the resident told	d l		copy of the community Perso		
me that she turned her call light on around		I		Service Provider Policy. Pers			
10:20 p.m. the night before to be taken off		I .		service providers will be expe			
					to sign in upon arrival and ou		
the bedpan. She stated that the CNA				upon departure and will prov	iae		
[#14] came into her room and asked her in a hateful tone what she needed. When the			I		acknowledgement of the community's policy and proc	edure	
	a hateful tone w	nat she needed. When t	ne			cuule	
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155221	B. WIN			05/31/20	011
			В. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				AST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH	CENTER			E HAUTE, IN47802		
					. 17/012, 114/7002		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	resident told her that she was on the bedpan the CNA [#14] started complaining to resident telling her that				associated with abuse/allega	itions	
					reporting.What measures wil	of abuse and timely	
					put in place or what systemic		
	she did not know	why I could not have			changes will be made to ens		
		dpan myself because all I			that the deficient practice do		
	1 -	tting on my butt doing			not recur:Education will be		
	1	nt then asked me, why			provided to all staff at the tim		
	ı ~	• •			hire on abuse/allegation of a		
		me. I told her that I did			identification and reporting.		
	l	esident then asked me if			education will be presented all-staff meetings at least eve		
		e bedpan before CNA			six months. Education will b		
	[#14] arrives. Re	esident appeared to be			provided to all staff at the tim		
	shaken up as I fir	nished getting her ready			hire on the grievance/concer		
	for bed. I told re	sident that the CNA			policy and procedure with ne		
	[#14] would not	be working in the health			for follow up in a timely manı		
		y. Resident replied by			This education will be preser		
	·	and appeared to calm			at all-staff meetings at least		
	down."	, and appeared to cann			six months. The Social Servi Director will bring any new	ce	
	down.				complaints to daily stand-up		
					meeting and will work, along	with	
	A document title				the administrator and other		
		ciplinary Action Form,"			management, to immediately	/	
	dated 11/11/10, r	egarding CNA #14,			identify and act on any comp	laints	
	completed by the	former DON on			that may involve abuse or		
	11/11/10, include	ed an occurrence or			possible abuse. All situation		
	violation of unsa				abuse/allegations of abuse v immediately investigated by	viii be	
		answering call light			community mangement inclu	_{idina}	
	1 ^	eft on bedpan and went to			the administrator. The	9	
	1 -	-			Department of Health will be		
	break making resident feel uncomfortable				notified of the investigation's		
		for assistance from this			onset and outcome. The MD		
	aide. Aide comes across as rude and intimidating. Plan of action: Aide suspended times 3 days for investigation upon findings. Aide to apologize to				responsible party and/or resi		
					will be notified of the investig		
					and its outcome. Social Serwill review the status of cond		
					and grievances including nev		
		nisunderstanding			concerns and grievances du		
	1	Supervisor Comments:			the daily stand-up meeting.		
		zaper (1501 Committee).			<u> </u>	l	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155221	B. WIN			05/31/2	U11
NAME OF	PROVIDER OR SUPPLIEF	2		1	ADDRESS, CITY, STATE, ZIP CODE		
חאאופ מ	SARDENS HEALTH	CENTED			AST DAVIS DRIVE HAUTE, IN47802		
					HAUTE, IN47002		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	1	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
1710		mplaints or occurrences		mo	grievance and concern will		DATE
	1 *	ther disciplinary action-up			remain on the agenda until		
	to and including				resolved. Resolutions will be		
	to and including	termination.			communicated to the resider	nt or	
	The Administrat	or was interviewed on			responsible party.How the corrective action(s) will be		
	1	a.m. The Administrator			monitored to ensure the defi	cient	
	1	made aware of the			practice will not recur:Audits	will	
					be conducted in regards to a		
	1 -	/8/10. The Administrator on what the former DON			training and reporting and all aspects of abuse prohibition		
	1				the DON and administrator of		
	1	t it was more of a care			their designee(s). These au		
	issue.				will be done at least monthly		
	CNIA //14/	C1 : 1			will include resident and fam	•	
	1	oyee file was reviewed on			interviews, employee intervie and records review. Results		
	1	o.m. A written document			be presented at the commun		
		as noted dated 10/30/10 to			Quality Assurance meeting for		
	1	. "[Name] Resident #65		least three months for evaluation	ation		
	_	er] told me today that she		and recommendations.			
	1	hts" because the CNA		Continuation of audits will be dependent on audit outcomes			
	1 *	CNA #14] would be taking					
		dent #65 stated that					
	1 -	en wonderful except for					
	1	NA. This CNA does not					
	1	ight and handles her					
	1	ike it does not matter that					
	1	e bathroom or that she is					
	_	said that she has					
		elf several times because					
	1	s not answered. She was					
	I -	en I told her this is the					
	1	lifferent CNA would be					
	-	second note, written on					
	the same docume	ent, dated 10/31/10					
	indicated Reside	ent #63 said last night was					
	much better and	the CNA was wonderful.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG.	00	COMPL	ETED
		155221	B. WING			05/31/2	011
				REET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER				AST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH	CENTER			HAUTE, IN47802		
(X4) ID		TATEMENT OF DEFICIENCIES	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PRE	I	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
		tter this a.m. Maybe a					
	change could be	made so she will not					
	dread the "nights." The report was signed						
	by RN # 16. An	y documentation of an					
	investigation or i	eporting of the allegation					
		ator was lacking. On					
		.m., the Administrator					
	1	The Administrator					
		not been made aware of					
		id was not aware of any					
	investigation bei	-					
	investigation ber	ing done.					
	A compact CNIA	41 Ala times and for the				i	
	1 1	#14's time card for the					
	1 ^	10 to 11/30/10, provided					
	1 -	5/31/11 at 12:50 p.m.					
	documented the	CNA worked on					
	11/1-4/10; 11/11	-12/10; 11/15-19/10;					
	11/22-24/10; 11/	25-26/10; 11/30/10.					
	 Documentation i	n CNA #14's employee					
		CNA resigned in April,					
	2011.	Civit resigned in 7 tpini,					
	2011.						
	Resident #63's of	osed clinical record was					
		5/11 at 10:15 a.m. An					
		vas noted of 10/26/10.					
		agnoses included, but					
		to, multiple traumatic					
		s] from a motor vehicle					
	accident.						
	An admission nu	rsing assessment,					
	completed on 10	/26/10 indicated the					
	resident was aler	t and oriented,					

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	PROVIDER OR SUPPLIER		1120 E	ADDRESS, CITY, STATE, ZIP CODI AST DAVIS DRIVE E HAUTE, IN47802	3	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	required assistant and one or two was The assessment autilized a brace a mobility, was coutilized a bedpar	rithout difficulties, ce of one for toileting, with dressing and bathing. Indicated the resident and wheelchair for ntinent of urine and it. itled "Facility Incident				
	Administrator or documented CN supervisor she had Resident #3 to "s documented indiwas notified and	" provided by the a 5/25/11 at 12:50 p.m. A #4 reported to the eard CNA #20 tell shut up." The report cated the Acting DON she and LPN #21 met and suspended her pending				
	indicated four re All four resident CNA that was ru people the way s identify the staff	of the investigation sidents were interviewed. It is indicated there was a de, and should not talk to the does, but did not talk to member. Interviews of the does were not included in the does.				
	5/25/11 at 12:50 indicated other s interviewed and	p.m. The Administrator taff members were not as far as the investigation mments were not regarded				

NAME OF PROVIDER OR SUPPLIER DAVIS GARDENS HEALTH CENTER (X3) ID SIMMARY STATEMINFOR DIRECTENCIS (BEACH DEPRICIENCY MUST BE PERCEDED BY PULL TAG 3. Interview of CNA #3 on 5/25/11 at 4:25 a.m. indicated RN #27 had talked to a former CNA #14 during the night shift regarding Resident #5 had called to the nursing station from her room one night with complaint of CNA #14 stating she would not come down and place the resident on the bed pan every time she turned the light on. CNA #3 attaced that RN #27 talked to CNA #14 and told her she would answer the resident's call light and be "nice" to her. CNA #3 indicated Resident #5 was alert and oriented. Interview of RN #27 on 5/27/11 at 6:05 p.m. indicated CNA #14 was "cross with me." RN #27 indicated the incident was probably occurred last fall. The RN also stated "I was afraid it will come back to me if I said too much." The RN indicated this was not reported to the Administrator or the Director of Nursing at the time of the incident. During interview of resident #5 on 5/24/11 at 2:55 p.m., the resident	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE S COMPL 05/31/2	ETED	
DAVIS GARDENS HEALTH CENTER IX91D SUMMARY STATEMENT OF DEFICIENCIES GACI DEFICIENCY MIST BE PERCEDED BY BILL. TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 3. Interview of CNA #3 on 5/25/11 at 4:25 a.m. indicated RN #27 had talked to a former CNA #14 during the night shift regarding Resident #5. CNA #3 indicated Resident #5 had called to the nursing station from her room one night with complaint of CNA #14 stating she would not come down and place the resident on the bed pan every time she turned the light on. CNA #3 stated that RN #27 talked to CNA #14 and told her she would answer the resident's call light and be "nice" to her. CNA #3 indicated Resident #5 was alert and oriented. Interview of RN #27 on 5/27/11 at 6:05 p.m. indicated Resident #5 had contacted him and indicated CNA #14 was "cross with me." RN #27 indicated he had talked to CNA #14 and told her to be "more kind." The RN indicated the incident was probably occurred last fall. The RN also stated "I was afraid it will come back to me if I said too much." The RN indicated this was not reported to the Administrator or the Director of Nursing at the time of the incident. During interview of resident #5 on	NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	1			
RECH DEFICIENCY MIST BE PERCEDED BY FILL TAG 3. Interview of CNA #3 on 5/25/11 at 4:25 a.m. indicated RN #27 had talked to a former CNA #14 during the night shift regarding Resident #5. CNA #3 indicated Resident #5 had called to the nursing station from her room one night with complaint of CNA #14 stating she would not come down and place the resident on the bed pan every time she turned the light on. CNA #3 indicated har RN #27 talked to CNA #14 and told her she would answer the resident's call light and be "nice" to her. CNA #3 indicated Resident #5 was alert and oriented. Interview of RN #27 on 5/27/11 at 6:05 p.m. indicated Resident #5 had contacted him and indicated CNA #14 was "cross with me." RN #27 indicated he had talked to CNA #14 and told her to be "more kind." The RN indicated the incident was probably occurred last fall. The RN also stated "I was afraid it will come back to me if I said too much." The RN indicated this was not reported to the Administrator or the Director of Nursing at the time of the incident. During interview of resident #5 on	DAVIS G	ARDENS HEALTH	CENTER		1			
a.m. indicated RN #27 had talked to a former CNA #14 during the night shift regarding Resident # 5. CNA #3 indicated Resident #5 had called to the nursing station from her room one night with complaint of CNA #14 stating she would not come down and place the resident on the bed pan every time she turned the light on. CNA #3 stated that RN #27 talked to CNA #14 and told her she would answer the resident's call light and be "nice" to her. CNA #3 indicated Resident #5 was alert and oriented. Interview of RN #27 on 5/27/11 at 6:05 p.m. indicated Resident #5 had contacted him and indicated CNA #14 was "cross with me." RN #27 indicated he had talked to CNA #14 and told her to be "more kind." The RN indicated the incident was probably occurred last fall. The RN also stated "I was afraid it will come back to me if I said too much." The RN indicated this was not reported to the Administrator or the Director of Nursing at the time of the incident. During interview of resident #5 on	PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
indicated CNA # 14 was nasty some times and that she had reported the CNA to the		a.m. indicated Riformer CNA #14 regarding Resident #5 had station from her complaint of CN not come down at the bed pan everyon. CNA #3 state CNA #14 and to the resident's call her. CNA #3 indicated Rimand oriented. Interview of RN p.m. indicated R him and indicate with me." RN #2 to CNA #14 and kind." The RN in probably occurre stated "I was aframe if I said too me this was not report or the Director of the incident. During interview 5/24/11 at 2:55 prindicated CNA #	N #27 had talked to a during the night shift ent # 5. CNA #3 indicated called to the nursing room one night with A #14 stating she would and place the resident on the state of the talked to the did her she would answer allight and be "nice" to dicated Resident #5 was did. #27 on 5/27/11 at 6:05 desident #5 had contacted do CNA #14 was "cross to indicated he had talked told her to be "more addicated the incident was ted last fall. The RN also had it will come back to much." The RN indicated to the Administrator of Nursing at the time of the incident #5 on th					

		X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE CO			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	А. В	BUILDING	00		COMPL	
		155221	B. V	VING			05/31/2	U11
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
					ST DAVIS DRIV			
DAVIS G	ARDENS HEALTH (CENTER		TERRE	HAUTE, IN4780)2		
(X4) ID		TATEMENT OF DEFICIENCIES		ID		LAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFI	ICIENCY)		DATE
	nurses.							
		Administrator on 5/27/11						
	_	cated he was unaware of						
	_	ng Resident #5 with CNA						
	#14.							
	4. Review of the	clinical record of						
	Resident # 48 on	5/25/11 at 1:05 p.m.						
	indicated a nursir	ng note dated 2/27/11 at						
	6:15 a.m. of "CN	IA reported to this nurse						
	that resident sitte	er [sic] was verbally rude						
	et [and] handled	resident rather roughly et						
	[and] that she did	dn't know what to do.						
		e needed to call DON						
		sing (not current DON)]						
	-	P [as soon as possible].						
	•	ill here CNA states yes.						
		to doorway of room sitter						
		ongings. This nurse						
		iate area. 0630 Sitter left						
	•	NA on phone c [with]						
		checked resident [no]						
		o] c/o [complaint of]						
	_							
		from resident . Per DON						
	_	document] et this nurse						
	_	et report incident. 0659						
	=	ne] et reported incident et						
		is fine has [no] injuries						
		50 Niece [name] returned						
		she [sitter] is not to have						
	-	ct c [with] resident.						
	DON and staff ac	dvised."						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	JU351	1 Facility I	D: 000126	If continuation sh	eet Pa	ge 10 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221		A. BUI	LDING	NSTRUCTION 00	(X3) DATE (COMPL 05/31/2	ETED	
		100221	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/01/2	
NAME OF	PROVIDER OR SUPPLIEF	R		1	AST DAVIS DRIVE		
	ARDENS HEALTH			1	HAUTE, IN47802		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG	†	Minimum Data Set	+	IAG	Dia relation (DATE
		ent dated 3/7/11 indicated					
	l ` ′						
	the resident was cognitively impaired.						
	Interview of Adr	ministrator on 5/26/11 at					
		ted he was unaware of					
	1 *	lministrator also indicated					
		loes not arrange for the					
	1	ne families of the					
	resident's arrang	e for the sitters.					
	Interview of curi	rent DON on 5/26/11 at 3					
	p.m. indicated as	n investigation had not					
	been completed	regarding the incident i.e.					
	talking to staff, o	or other residents.					
	5 Interview of E	Resident # 42 on 5/24/11					
		ted that 1-2 months ago					
		LPN #19 had hurt her					
	_	statement she made. The					
	_	ne had stated to the nurse					
		k and tired of being here"					
		9 had stated "you aren't					
		o is tired of you being					
	1 *	ent stated she had talked					
	1	administration about it					
		nember specific person.					
		ed she had no concerns					
	currently with L	PN #19.					
		Administrator on 5/26/11					
	_	cated he was unaware of					
	1 -	th Resident #42 and LPN					
	#19.						

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155221	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/31/2011
	ROVIDER OR SUPPLIER		STREET A 1120 EA	ADDRESS, CITY, STATE, ZIP CODE AST DAVIS DRIVE E HAUTE, IN47802	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE
F0226 SS=E	indicated Reside had hurt her feels tired of her too. It thorough in that interview with Roonly. 3.1-28(c) 3.1-28(d) The facility must dwritten policies an mistreatment, negand misappropriat Based on intervier facility failed to procedures for 3 reviewed in that allegations to the state agency and required, thorough provision of proteinvestigation were #63, #3, #5, #48, Findings include 1. On 5/26/11 at compliance/grieves	-	F0226	What corrective action(s) wil accomplished for those resic found to have been been affiby the deficient practice: Res #65 is no longer at the facilit Residents #3, 48, 42, and 5 had no further incidents. CN #3 and #14 are no longer employed at the facility. The private sitter for #48 no longer cares for the resident. LPN # was suspended for investigation of allegation of abuse on 5/27/2011. Investigation inclinterviewing resident #42, interviewing other residents, interviewing coworkers, and notifying the Indiana Departr of Health. Based on the investigation's outcome the	dents ected ident y. have lAs er er er ton

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155221	B. WIN			05/31/2	U11
NAME OF	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				1	AST DAVIS DRIVE		
DAVIS G	SARDENS HEALTH	CENTER		TERRE	HAUTE, IN47802		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	1 *	h received date of 11/8/10			employee returned to work; tresident and the Indiana	ine	
	was noted of "Na	ame of person making			Department of Health were		
	complaint [name	e] [Resident #63] with the			notified of the outcome. How	other	
	following docun	nentation: "Concern			residents having the potentia		
	report to Social	Services staff- [names]			be affected by the same defi		
	Name and title o	f person completing			practice will be identified and		
		W." The description of			what corrective action(s) will taken:All residents have the	pe	
	1	ed of: "States that CNA			potential to be effected by th	is	
		#14] made her feel like			deficient practice. All staff w		
	1	th trouble, was distant and			educated on the community'		
	1	she came in to provide			policy and procedure associ		
	1	-			with abuse/allegations of abo		
		old her when answering a			identification and timely repo	-	
	1	ut you on the bedpan-but			with emphasis on: the need report to the supervisor, DOI		
	1	ınch-left call unattended			the administrator with nights		
		ime (1 hour) would have			weekends or holidays not be		
		Vitnessed by [names of			an exception; the need for th		
	social service an	d leisure service			accused individual to be rem	oved	
	workers."] An a	dditional note on the			from the community		
	form included "I	Res [resident] was tearful			immediately; thorough investigation of the situation	with	
	during interview	when began thinking of			documented interviews with		
	the CNA. Stated	d she "tensed up" before			staff (on all shifts) who have	had	
	CNA came in."				contact with the resident dur		
					the alleged event; notification		
	Documentation of	on a copy of the Report of			the responsible party and Ml timely manner; and,	ווכ a	
		mplaint form indicated			abuse/allegations of abuse b	_{oy}	
	1	as reported to the former			visitors, family members, or	´	
	1 -	for follow up. The			anyone in contact with a resi		
		luded interview of CNA			mandates the same reporting	-	
	1	4. The written statement			requirements and follow up a with community employees.		
					staff will be educated on the	^"	
		included, but was not			grievance/concern policy and	d l	
		v days after the resident in			procedure with need for follo		
		was admitted she started			in a timely manner. The Soc		
	1 -	was wrong with the CNA			Service Director will bring ar		
	on night shift	she stated that the CNA			new complaints to daily stan	d-up	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155221		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURV COMPLETED 05/31/2011			LETED	
	PROVIDER OR SUPPLIER		STRI 112	EET ADDRESS, CITY, STATE, ZIP CODE 20 EAST DAVIS DRIVE RRE HAUTE, IN47802		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE APPROF	BE RIATE	(X5) COMPLETION DATE
	always mad about resident then start she asked me if I asked the resident if she uses the benight. The resident ries to use the benight. The resident results in her resident appeared about the situation [#14] gets mad at change the bed. The me why the CNA that way. The new that she turned 10:20 p.m. the new that she turned 10:20 p.m. the new that she turned a hateful tone where it is to make the complaining to resident told here bedpan the CNA complaining to resident told here bedpan the CNA complaining to reshe did not know got her off the bewas doing was sonothing. Resident contains the contains the contains the contains the contains the complaining to reshe and the compla	hy and acted like she was at something. The red to act nervous and I would put a brief on her. Lent why she wanted it on edpan throughout the ent then stated that she edpan but the CNA [#14] answer her call light, it er wetting the bed. The did upset while talking on saying that the CNA at her when she has to The resident kept asking A [#14] was treating her ext day, the resident told ed her call light on around ight before to be taken off stated that the CNA her room and asked her in that she was on the L[#14] started esident telling her that why I could not have edpan myself because all I litting on my butt doing int then asked me, why dime. I told her that I did esident then asked me if the bedpan before CNA esident appeared to be mished getting her ready esident that the CNA		meeting and will work, alor the administrator and other management, to immediate identify and act on complete that may involve abuse or possible abuse. The commodity in the recommender of the recommender of the resident of their responsitions of the community of acknowledgement of the community of abuse and timely reporting. What measures put in place or what syste changes will be made to that the deficient practice not recur: Education will be provided to all staff at the hire on abuse/allegation of identification and reporting education will be present all-staff meetings at least six months. Education with for follow up in a timely more of the ducation will be present all-staff meetings at least six months. Education will be present all-staff meetings at least six months. Education will be present all-staff meetings at least six months. Education will be present all-staff meetings at least six months. The Social Six months.	er rely ints rely ints rely ints rely ints rely ints rely ints related the esires of the esires related resonal ersonal ersona	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155221 05/31/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1120 EAST DAVIS DRIVE DAVIS GARDENS HEALTH CENTER TERRE HAUTE, IN47802 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE [#14] would not be working in the health Director will bring any new complaints to daily stand-up center on that day. Resident replied by meeting and will work, along with stating "GOOD", and appeared to calm the administrator and other down." management, to immediately identify and act on any complaints that may involve abuse or A document titled possible abuse. All situations of "Counseling/Disciplinary Action Form," abuse/allegations of abuse will be dated 11/11/10, regarding CNA #14, immediately investigated by completed by the former DON on community manaement including the administrator. The 11/11/10, included an occurrence or Department of Health will be violation of unsatisfactory work notified of the investigation's performance not answering call light onset and outcome. The MD and timely-resident left on bedpan and went to responsible party and/or resident will be notified of the investigation break making resident feel uncomfortable and its outcome. Social Service and afraid to ask for assistance from this will review the status of concerns aide. Aide comes across as rude and and grievances including new concerns and grievances during intimidating. Plan of action: Aide the daily stand-up meeting. Each suspended times 3 days for investigation grievance and concern will upon findings. Aide to apologize to remain on the agenda until resident for any misunderstanding resolved. Resolutions will be between them." Supervisor Comments: communicated to the resident or responsible party. How the "Any further complaints or occurrences corrective action(s) will be will result in further disciplinary action-up monitored to ensure the deficient to and including termination." practice will not recur: Audits will be conducted in regards to abuse training and reporting and all The Administrator was interviewed on aspects of abuse prohibition by 5/27/11 at 9:40 a.m. The Administrator the DON and administrator or indicated he was made aware of the their designee(s). These audits allegation on 11/8/10. The Administrator will be done at least monthly and will include resident and family indicated based on what the former DON interviews, employee interviews, told him thought it was more of a care and records review. Results will issue. be presented at the community's Quality Assurance meeting for at least three months for evaluation CNA #14's employee file was reviewed on

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JU3511

Facility ID:

000126

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA	(X2	2) MULTIPLE CO			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Α.	BUILDING	00		COMPL	
		155221	В.	WING		_	05/31/2	011
NAME OF F	PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZI	P CODE		
חשאופ פ	ARDENS HEALTH (CENTED			AST DAVIS DRIVE HAUTE, IN47802			
					11/1012, 11/4/7002			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIO			(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO T DEFICIENCY	HE APPROPRIAT	ΓE	DATE
		o.m. A written document			and recommendat	ions.		
		as noted dated 10/30/10 to			Continuation of au	dits will be	!	
		. "[Name] Resident #63			dependent on aud	it outcome	S.	
		er] told me today that she						
	=	hts" because the CNA						
	_	CNA #14] would be taking						
	- 1	dent #63 stated that						
	everyone has bee	en wonderful except for						
	<u>-</u>	NA. This CNA does not						
	•	ight and handles her						
	roughly, acting li	ike it does not matter that						
	she has to use the	e bathroom or that she is						
	in pain. She also	said that she has						
	urinated on herse	elf several times because						
	the call light was	s not answered. She was						
	very relieved wh	nen I told her this is the						
	weekend and a d	lifferent CNA would be						
	here tonight. As	second note, written on						
	the same docume	ent, dated 10/31/10						
	indicated Resider	ent #63 said last night was						
	much better and	the CNA was wonderful.						
	She is feeling bet	tter this a.m. Maybe a						
	_	made so she will not						
	_	s." The report was signed						
		y documentation of an						
	_	reporting of the allegation						
		ator was lacking. On						
	-	o.m., the Administrator						
		. The Administrator						
		not been made aware of						
	_	nd was not aware of any						
	investigation being	ng done.						
		W4.00						
	A copy of CNA #	#14's time card for the						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	JU35	11 Facility I	D: 000126 If	continuation sl	neet Pa	ge 16 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155221	B. WIN			05/31/20	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				AST DAVIS DRIVE		
	ARDENS HEALTH	CENTER		1	HAUTE, IN47802		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENC!)		DATE
	period of 10/30/10 to 11/30/10, provided						
	*	5/31/11 at 12:50 p.m.					
	documented the						
	11/1-4/10; 11/11-	-12/10; 11/15-19/10;					
	11/22-24/10; 11/2	25-26/10; 11/30/10.					
	Documentation in CNA #14's employee						
	file indicated the	CNA resigned in April,					
	2011.	1 ,					
	Resident #63's closed clinical record was						
	reviewed on 5/26/11 at 10:15 a.m. An						
		vas noted of 10/26/10.					
		agnoses included, but					
		to, multiple traumatic					
	" -	s] from a motor vehicle					
	accident.						
ı	An admission nu	rsing assessment,					
	completed on 10	/26/10 indicated the					
	resident was aler	t and oriented,					
		vithout difficulties,					
		ce of one for toileting,					
	·	vith dressing and bathing.					
		ndicated the resident					
		and wheelchair for					
	mobility, was continent of urine and						
	utilized a bedpan	l.					
	2. A document to	itled "Facility Incident					
		" provided by the					
		1 5/25/11 at 12:50 p.m.					
		A #4 reported to the					
		eard CNA #20 tell					
	Supervisor she lit	ωια CINA #40 ICII					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221		(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE S COMPL 05/31/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>		l	ADDRESS, CITY, STATE, ZIP CODE		
DAVIS G	ARDENS HEALTH	CENTER		l	HAUTE, IN47802		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	documented indi was notified and	shut up." The report cated the Acting DON she and LPN #21 met nd suspended her pending					
	indicated four re All four resident CNA that was ru people the way s identify the staff	of the investigation sidents were interviewed. s indicated there was a de, and should not talk to he does, but did not member. Interviews of errs were not included in					
	The Administrator was interviewed on 5/25/11 at 12:50 p.m. The Administrator indicated other staff members were not interviewed and as far as the investigation the residents' comments were not regarded as abusive.						
	a.m. indicated R former CNA #14 regarding Resident #5 had station from her complaint of CN not come down a the bed pan ever on. CNA #3 state	NA#3 on 5/25/11 at 4:25 N #27 had talked to a during the night shift ent # 5. CNA #3 indicated called to the nursing room one night with A #14 stating she would and place the resident on by time she turned the light ed that RN #27 talked to lid her she would answer					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
ANDILAN	OF CORRECTION	155221	A. BUII		00	05/31/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				AST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH (CENTER		1	HAUTE, IN47802		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		l light and be "nice" to		IAU			DATE
		icated Resident #5 was					
	alert and oriented						
	Interview of RN #27 on 5/27/11 at 6:05 p.m. indicated Resident #5 had contacted						
	•	d CNA #14 was "cross					
	with me." RN #2	7 indicated he had talked					
	to CNA #14 and	told her to be "more					
	kind." The RN in	dicated the incident was					
	probably occurred last fall. The RN also						
	stated "I was afra	aid it will come back to					
	me if I said too n	nuch." The RN indicated					
	this was not repo	rted to the Administrator					
	or the Director of	f Nursing at the time of					
	the incident.						
	During interview	of resident #5 on					
	5/24/11 at 2:55 p	.m., the resident					
	indicated CNA#	14 was nasty some times					
	and that she had	reported the CNA to the					
	nurses.						
	Interview of the	Administrator on 5/27/11					
		cated he was unaware of					
	_	ng Resident #5 with CNA					
	#14.	-					
		nical record of Resident # 48					
	_	.m. indicated a nursing note					
		5 a.m. of "CNA reported to ent sitter [sic] was verbally					
		d resident rather roughly et					
	[and] that she didn't	know what to do. Advised					
	CNA she needed to	call DON [Director of Nursing					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221		(X2) MU A. BUIL B. WINC	DING G	NSTRUCTION 00	(X3) DATE S COMPL 05/31/2	ETED	
	PROVIDER OR SUPPLIER			1120 EA	DDRESS, CITY, STATE, ZIP CODE AST DAVIS DRIVE HAUTE, IN47802	-	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	possible]. Asked if some this nurse went to be gathering her belong immediate area. 063 CNA on phone c [woresident [no] injurie problems or pain from CNA doc [document et report incident. Our reported incident et [no] injuries or ill et returned callper fa any further contact of staff advised." The most recent Minassessment dated 3/cognitively impaired incident et group in the resident's arrange for the some the resident's arrange for the some the resident's arrange in the resident's arrange for the some indicated an investigation of the residents. 5. Interview of Residents indicated that 1-2 murse that "she was and that LPN #19 had one who is tired of systated she had talked staff in the resident in the	istrator on 5/26/11 at 1:20 p.m. aware of incident. The indicated that the facility does itters and that the families of e for the sitters. DON on 5/26/11 at 3 p.m. gation had not been completed in i.e. talking to staff, or other i.e. talking to staff, or other dent # 42 on 5/24/11 at 11 a.m. onths ago the night nurse LPN lings due to a statement she stated she had stated to the sick and tired of being here ad stated "you aren't the only you being here." The resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155221 05/31/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1120 EAST DAVIS DRIVE DAVIS GARDENS HEALTH CENTER TERRE HAUTE, IN47802 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE specific person. The resident stated she had no concerns currently with LPN #19. Interview of the Administrator on 5/26/11 at 3:45 p.m. indicated he was unaware of any concerns with Resident #42 and LPN #19. Review of investigation dated 5/27/11 indicated Resident #42 stated LPN #19 had hurt her feelings by saying she was tired of her too. The investigation was not thorough in that the investigation included interview with Resident #42 and LPN #19 only. Review of facility's current policy and procedure titled "Reportable Unusual Occurrences" dated 1/25/2006 on indicated "the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State Survey and Certification Agency...ABUSE- physical, sexual, verbal and/or mental (known and/or alleged) ..." Review of facility's current policy and procedure titled "Abuse Investigations" dated 4/2010 on 5/27/11 at 4 p.m. indicated "All reports of resident abuse, neglect, and injuries of unknown source shall be promptly and thoroughly investigated by facility management...3. The individual conducting the investigation will, as a minimum: ...b. Review the resident's medical record to determine events leading up to the incident; c. Interview the person (s) reporting the incident; d. Interview any witnesses to the incident; e. Interview the resident (as medically appropriate); ...g. Interview staff

members (on all shifts) who have had contact with

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			VEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETE	D
		155221	B. WING		05/31/2011	l
NAME OF B	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
TWINE OF T	KOVIDEK OK GOLTEIEN		I	AST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH	CENTER	TERRI	E HAUTE, IN47802		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re CO	OMPLETION DATE
IAG		he period of the alleged	IAG			DATE
	•	w the resident's roommate,				
family members, and visitors; i. Interview other						
	-	he accused employee provides				
		l j. Review all events leading				
	up the alleged incide	ent"				
	3.1-28(a)					
	3.1-20(a)					
F0279	A facility must use	the results of the	i			
SS=D	•	velop, review and revise the				
00-D		nensive plan of care.				
	The facility must d	evelop a comprehensive				
		resident that includes				
	•	tives and timetables to meet				
		al, nursing, and mental and				
		Is that are identified in the				
	comprehensive as	sessment.				
	The care plan mus	st describe the services that				
		d to attain or maintain the				
		practicable physical,				
		osocial well-being as				
	-	83.25; and any services that e required under §483.25				
		ed due to the resident's				
		under §483.10, including the				
		tment under §483.10(b)(4).				
	Based on intervio	ew and record review,	F0279	What corrective action(s) wil		06/29/2011
	the facility failed	to develop a		accomplished for those resid		
		are plan for 1 of 1		found to have been affected		
	*	ed, receiving bruises		the deficient practice:Reside #28 was assessed by her MI		
	1551401115 10 110 W			#20 was assessed by Hel IVII	J and	

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED	
		155221	B. WIN			05/31/2	011	
NAME OF	PROVIDER OR SUPPLIER		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF	PROVIDER OR SUPPLIER			1120 EA	AST DAVIS DRIVE			
	SARDENS HEALTH			<u> </u>	HAUTE, IN47802			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION	
TAG	 	LSC IDENTIFYING INFORMATION)	-	TAG			DATE	
	1	in a sample of 15 in that			found to have no serious inju related to this deficient pract			
	a plan of care ide	entified the resident as			The resident's care plan was			
	requiring extens	ive assistance, but failed			reviewed and updated to inc			
	to identify specia	fic approaches to be			a plan for transfers with exte			
	utilized during tl	ne physical transfers.			assist of one with gait belt ar			
	(Resident #28)	• •			use of hand rails and toilet ri			
	,				as applicable. Orders for ph			
	Findings include	··			and occupational therapy we obtained for Resident #28	ere		
	1 manigs merade	·•			to focus on transfers, wheeld	hair		
	D : : : : : : : : : : : : : : : : : : :				management, and therapeut			
	During initial tour on 5/23/11 at 11:15				activities.How other resident			
	a.m., the DON indicated resident #28				having the potential to be aff	ected		
	required extensive assist for toileting with				by the same deficient praction			
	staff assistance and was alert/oriented.				be identified and what correct	ctive		
					action(s) will be taken:All	_		
	Resident #28's c	linical record was			residents receiving assistant with transfers have the poter			
	reviewed on 5/2:	5/11 at 12:05 p.m.			to be affected by this deficier			
		•			practice. Transfer instruction			
	On 5/12/11 at 2 i	p.m., nurses notes			each applicable resident will	be		
		(power of attorney)			reviewed and revised as nee			
	1	ing on buttock pt [patient]			by the Director of Nursing or			
	states its from w			designee so that they are specific as to number of staff needed to				
					assist. In addition, nursing st			
		acted pt to try to seat (sic)			and rehabilitation staff will we			
	down easier."				together to assess transfer n			
					according to resident's prefe			
		30 p.m., nurses notes			for assistance; resident's mo	bility		
	indicated "bruise	e to bil (bilateral) buttock			and degree of dependency;			
	cont (continue) f	ading resident frequently			resident's size; resident's weight-bearing ability; reside	nt's		
	flops in chair et	[and] commode freq			cognitive status; and whethe			
	(frequently) obse	erved self transferring or			resident is usually cooperative			
	observed attemp	_			with staff. It will then be veri			
		5			that written instructions to Cl			
	A quarterly Mini	imum Data Set (MDS)			and the plan of care properly			
	1 1	· /			reflect transfer instructions. CNAs will have a skill verification.			
	1	d 12/14/11, indicated the			completed regarding transfer			
	resident required	l extensive assist of one			Completed regarding transfer	1		

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155221	B. WIN			05/31/2	011
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	C		1120 EA	AST DAVIS DRIVE		
	ARDENS HEALTH			TERRE	HAUTE, IN47802		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	person for transf	ers. An annual Minimum			technique and will be trained		
	Data Set (MDS) assessment, dated 3/2/11,				how to access resident-spec		
	indicated the res	ident required extensive			transfer instructions. Nursing	-	
	assist of one pers	•			management will do at least observations on each shift at		
	dissist of one per	son for transfers.			least two times per week for		
	A C 4:41. 1 !!C	Dia C C			least four weeks of CNAs	a.	
		are Plan Conference			completing transfers by prov	idina	
	1	14/6/11, identified a			assistance or extensive	J	
	current concern,	with a start date of			assistance. Deficient		
	12/23/10, indica	ting the resident requires			observations will be address		
	extensive assist v	with transfers. A goal			through immediate retraining	and	
		ating the resident will			counseling. The process of		
		rs with the assistance of			communicating and docume		
	_				change in plan of care will be discussed in daily stand-up	2	
		evices as required. An			meeting. Changes to a plan	of	
		noted of "Transfer using			care will be timely and	OI	
	the transfer boar	d/lift devices."			appropriate and, when applic	cable.	
					will also reflect in written	,	
	During interview	on 5/26/11 at 1 p.m., the			instructions to CNAs. Licens	sed	
	_	e to identify who was to			staff will be inserviced on the	;	
		one or two people would			comprehensive care planning		
					process. What measures wi		
	_	resident with transfers,			put in place or what systemic		
		to identify type of			changes will be made to ens		
	assistive devices	that should be utilized.			that the deficient practice do not recur:Newly hired license		
					staff orientation will include	,u	
	3.1-35(b)(1)				training on the comprehensive	/e	
					care planning process. New		
					hired CNAs will have a skill	-	
					verification completed regard		
					transfer technique and will be	e	
					trained on how to access		
					resident-specific transfer	tions	
					instructions. Transfer instruc		
					for each applicable resident to be reviewed and revised as	vvIII	
					necessary at least quarterly	hv	
					the interdisciplinary care plan		
					team. The instructions will b		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST DAVIS DRIVE	COMPLETED 5/31/2011
DAVIS GARDENS HEALTH CENTER TERRE HAUTE, IN47802	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETED	ce y se e e e in ty I.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155221		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV A. BUILDING (00) COMPLETE 05/31/2011			ETED		
		155221	B. WIN		<u> </u>	05/31/20	011
	ROVIDER OR SUPPLIER			1120 EA	DDRESS, CITY, STATE, ZIP CODE IST DAVIS DRIVE HAUTE, IN47802		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWINGBIG BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	_	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	-	DATE
	Each resident must must provide the not attain or maintal physical, mental, a in accordance with assessment and p Based on record the facility failed requiring assistant receiving care to 5 residents review assist with manual of 15, in that the the resident was sitting down to he establish and imprevent the injurt. Findings include During initial towarm, the DON in required extensive the assistance of alert/oriented. Resident #28's clareviewed on 5/25.	at receive and the facility necessary care and services in the highest practicable and psychosocial well-being, in the comprehensive plan of care. The review and interview, in the ensure a resident nece with transfers was prevent bruising for 1 of wed requiring extensive all transfers, in a sample facility was identifying receiving bruises from ard, and failed to plement approaches to ries. (Resident #28) The resident #28 The real of the facility in the resident #28 The real of			CROSS-REFERENCED TO THE APPROPRIAT	be ents by nt D and ry ce ude nsive d ser ysical re hair c sected e will tive e tial at the section be ded her ecific to	
	_	by) 5 cm Bruise to [right]			and rehabilitation staff will wo		
		denies pain et (and) has			together to assess transfer no		
		1			according to resident's prefer		
	no recollection of	n how bruise was			for assistance; resident's mol	DIIITY	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY 00 COMPLETED				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00		
		155221	B. WIN	G		05/31/20)11
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	AST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH	CENTER		TERRE	HAUTE, IN47802		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	`	medical doctor) faxed,			and degree of dependency; resident's size; resident's		
	family updated Will monitor."				ent's		
					weight-bearing ability; reside cognitive status; and whethe		
	The next nurses i	note concerning the			resident is usually cooperative	/e	
	bruising was on	12/9/10 at 10:00 a.m., of			with staff. It will then be veri		
	"bruise on buttoc	k slowly fading, denies			that written instructions to CI		
	pain or discomfo	rt. No further			and the plan of care properly reflect transfer instructions.		
	documentation w	as noted in the nurses			CNAs will have a skill verification		
	notes concerning	bruising on the buttocks			completed regarding transfe		
	until 5/12/11.				technique and will be trained		
	(Marie C) 12/111				how to access resident-spec		
	On 5/12/11 at 2 p.m., nurses notes indicated "POA (power of attorney)				transfer instructions. Nursing management will do at least		
					observations on each shift a		
		ng on buttock pt [patient]			least two times per week for	at	
	states its from wh				least four weeks of CNAs		
		cted pt to try to seat (sic)			completing transfers by prov	iding	
	down easier."	eted pt to try to seat (sie)			assistance or extensive assistance. Deficient		
	down casici.				observations will be address	ed	
	On 5/16/11 at 1:3	20			through immediate retraining		
		80 p.m., nurses notes			counseling.The process of		
		to bil (bilateral) buttock			communicating and docume		
	' '	ading resident frequently			change in plan of care will be discussed in daily stand-up		
	-	and] commode freq			meeting. Changes to a plan	of	
		erved self transferring or			care will be timely and	.	
	observed attempt	ing to."			appropriate and, when applic	cable,	
					will also reflect in written		
		mum Data Set (MDS)			instructions to CNAs. Licens staff will be inserviced on the		
		d 12/14/11, indicated the			comprehensive care plannin		
	resident required	extensive assist of one			process. What measures wi		
	person for transfe	ers. An annual Minimum			put in place or what systemic		
	Data Set (MDS)	assessment, dated 3/2/11,			changes will be made to ens		
	indicated the resi	dent required extensive			that the deficient practice do not recur:Newly hired license		
	assist of one pers	on for transfers.			staff orientation will include	~	
	_				training on the comprehensive	/e	
	A "Care Plan Con	nference Summary" dated			care planning process. New	ly	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155221 05/31/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1120 EAST DAVIS DRIVE DAVIS GARDENS HEALTH CENTER TERRE HAUTE, IN47802 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 4/6/11, identified a current concern, with a hired CNAs will have a skill verification completed regarding start date of 12/23/10, indicating the transfer technique and will be resident requires extensive assist with trained on how to access transfers. A goal was noted, indicating resident-specific transfer instructions. Transfer instructions the resident will complete transfers with for each applicable resident will the assistance of 1-2 people/lift devices as be reviewed and revised as required. An intervention was noted of necessary at least quarterly by "Transfer using the transfer board/lift the interdisciplinary care plan devices." team. The instructions will be specific as to number of staff needed to assist. Nursing staff A facility "Shower and Body Check" and rehabilitation staff will work dated 5/12/11, was received from the together to assess transfer needs DON on 5/26/11 at 12:05 p.m. according to resident's preference for assistance; resident's mobility Documentation indicated that the resident and degree of dependency; had bruises all over "butt". The form was resident's size; resident's signed by CNA #5 and RN #18. weight-bearing ability; resident's cognitive status; and whether the resident is usually cooperative During interview of the DON on 5/26/11 with staff. The MDS coordinator at 11:45 a.m., the DON indicated CNAs will be responsible to assure care do a skin check on resident's on shower plans are audited for accuracy days and document on shower sheets, and during care plan meetings. The MDS coordinator will also ensure notify the nurse if a concern is found. that changes in care routine are The DON indicated the bruising reflected in the plan of care. The documented in the nurses notes on scheduler will be responsible to 12/8/10, had documentation on an ensure that changes in care routine are accurately reflected in incident report. The DON indicated the written instructions to the CNAs. incident report was filled out by LPN #19, Resident and/or responsible party and the documentation indicated LPN #19 and MD involvement in the care felt the bruise was from the resident plan process will be encouraged. How the corrective action(s) will plopping down on the toilet, and the be monitored to ensure the resident was instructed not to plop down deficient practice will not when sitting. The DON indicated no recur:The MDS nurse and further investigation was implemented scheduler will audit tranfer assessments, care plan changes concerning the bruising. JU3511

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
155221		155221	B. WING			05/31/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
D 43 (10 0	ABBENIO LIEALTI.	OFNITED			AST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH	CENTER		I IERRE	HAUTE, IN47802		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					and written instructions to CN		
	During interview	on 5/26/11 at 1 p.m., the			including care plan changes		
	1	she had spoke with CNA			written instructions to CNAs		
		DON indicated the			relate to transfers. Results v	vill be	
					presented at the Quality		
		they transfer resident			Assurance meeting for three months for evaluation and		
	#28 with one CN	JA, and that the resident				ıtion	
	pulls self up with	n the grab bar and then			recommendations. Continuation of audits will be dependent on audit outcomes.What corrective		
	the CNA places	her hands around the					
		o help control the			action(s) will be accomplishe		
	resident to sit do	•			those residents found to have		
	l resident to sit do	WII.			been affected by the deficien	ıt	
	A facility policy, dated 10/09, titled "Safe Lifting and Movement of Residents"				practice:Resident #28 was		
					assessed by her MD and fou	nd to	
					have no serious injury relate	d to	
	received on, 5/26	6/11 at 3:35 p.m., from			this deficient practice The		
		r, documentation			resident's care plan was revi		
		ng staff in conjunction	and updated to include a plan for transfers with extensive assist of				
		-			one with gait belt and use of		
		tation staff, shall assess			rails and toilet riser as applic		
		ent's needs for transfer			Orders for physical and	abic.	
	assistance on an	ongoing basis. Staff will			occupational therapy were		
	document reside	nt transferring and lifting			obtained for Resident #28		
	needs in the care	plan. Such assessment			to focus on transfers, wheeld	hair	
		Resident's preferences			management, and therapeut	ic	
		Resident's mobility			activities.How other residents	S	
		•			having the potential to be aff		
	1	idency); c. Resident's size;			by the same deficient practic		
	1	ng ability; e. Cognitive			be identified and what correct	tive	
	status; f. Wheth	ner the resident is usually			action(s) will be taken:All		
	cooperative with	staff"			residents receiving assistant with transfers have the poter		
					to be affected by this deficier		
	3.1-37(a)				practice. Transfer instruction		
	3.1-3/(a)				each applicable resident will		
					reviewed and revised as nee		
					by the Director of Nursing or	her	
					designee so that they are sp		
					as to number of staff needed		
					assist. In addition, nursing st	aff	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DINI DING 00		00	COMPLETED		
		155221	A. BUILDING		05/31/2011			
		100221	B. WIN			00/01/2		
NAME OF I	PROVIDER OR SUPPLIER	L		l	ADDRESS, CITY, STATE, ZIP CODE			
				l	AST DAVIS DRIVE			
DAVIS G	ARDENS HEALTH	CENTER		TERRE	HAUTE, IN47802			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE	
					and rehabilitation staff will w			
					together to assess transfer r			
					according to resident's prefe			
					for assistance; resident's mo	bility		
					and degree of dependency;			
					resident's size; resident's			
					weight-bearing ability; reside			
					cognitive status; and whether			
					resident is usually cooperative with staff. It will then be veri			
					that written instructions to C			
					and the plan of care properly			
					reflect transfer instructions.			
					CNAs will have a skill verific			
					completed regarding transfe			
					technique and will be trained			
					how to access resident-spec			
					transfer instructions. This transfer			
					will be coordinated by the DI	•		
					of Nursing or her designee.			
					process of communicating a	nd		
					documenting change in plan	of		
					care will be discussed in dai	•		
					stand-up meeting. Changes			
					plan of care will be timely an			
					appropriate and, when applicate will also reflect in written	cable,		
					instructions to CNAs. Licens	sed		
					staff will be inserviced on the			
					comprehensive care plannin	•		
					process. What measures wi	•		
					put in place or what systemic			
					changes will be made to ens			
					that the deficient practice do			
					not recur:Newly hired license	ed		
					staff orientation will include			
					training on the comprehensi			
					care planning process. New	'ly		
					hired CNAs will have a skill			
					verification completed regard	-		
					transfer technique and will b	е		
					trained on how to access			

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PRINTED: 07/07/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221		A. BUILDING	00	COMPLET 05/31/20	ГЕО	
		100221	B. WING		03/31/20	1 I
NAME OF F	PROVIDER OR SUPPLIER		l	ADDRESS, CITY, STATE, ZIP CODE		
D 41 // 2 -	ADDENO HETTE	OFNITED	l l	AST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH (CENTER	TERRE	HAUTE, IN47802		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	IATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	.	DATE	
				resident-specific transfer instructions. Transfer instructions. Transfer instructions be reviewed and revised as necessary at least quarterly the interdisciplinary care pleam. The instructions will specific as to number of staneeded to assist. Nursing and rehabilitation staff will utogether to assess transfer according to resident's pref for assistance; resident's mand degree of dependency resident's size; resident's weight-bearing ability; resident's weight-bearing ability; resident's usually cooperate with staff. The MDS coordin will be responsible to assurplans are audited for accurding care plan meetings. MDS coordinator will also esthat changes in care routing reflected in the plan of care scheduler will be responsible ensure that changes in care routine are accurately reflewritten instructions to the CResident and/or responsible and MD involvement in the plan process will be encounted to ensure the deficient practice will not recur: The MDS nurse and scheduler will audit tranfer assessments, care plan chand written instructions to the care assessments, care plan chand written instructions to the care assessments, care plan chand written instructions to the care assessments, care plan chand written instructions to the care assessments, care plan chand written instructions to the care assessments, care plan chand written instructions to the care assessments, care plan chand written instructions to the care assessments, care plan chand written instructions to the care assessments, care plan chand written instructions to the care assessments, care plan chand written instructions to the care assessments, care plan chand written instructions to the care assessments.	uctions t will s / by an be aff staff work needs erence hobility ; lent's er the tive ator e care acy The ensure e are c re e are le to e cted in NAs. e party care raged.) will anges	
				including care plan change		
				written instructions to CNA		
				relate to transfers. Results		

000126

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFI		IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED		
	155221		B. WING 05/3			05/31/2	05/31/2011	
			D. ((1))		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				l	AST DAVIS DRIVE			
DAVIS G	ARDENS HEALTH (CENTER		1	E HAUTE, IN47802			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
1110	REGOLFHORTOR	ESC IDEIVIII TIIVO II I ORIMITION		1710	presented at the Quality		DITE	
					Assurance meeting for at			
					least three months for evalua	ation		
					and recommendations.			
					Continuation of audits will be			
					dependent on audit outcome	S.		
F0323		nsure that the resident						
SS=D		ins as free of accident sible; and each resident						
	•	supervision and assistance						
	devices to prevent							
		ation, interview, and	F0	323	What corrective action(s) will	be	06/29/2011	
		ne facility failed to ensure			accomplished for those resid			
	· · · · · · · · · · · · · · · · · · ·	remained free of accident			found to have been affected			
					the deficient practice:Reside			
		wing manufacturer's			#43 and #20 suffered no adv effect from this deficient prac			
	_ ~	sharp objects e.g. knife			Resident #59 was not injured			
	out of reach for 2				result of the incident. A physic			
		echanical lift and/or			order for the Maxi Move			
	cognitively impa	ired with independent			mechanical lift was obtained	for		
	ambulation in a s	ample of 15 and 1 of 1			resident #43 and the care pla	an for		
	residents transfer	red by mechanical lift in			transfer was revised to be			
	a supplemental sa	ample of 7. [Resident			specific and appropriate. Wr	ritten		
	#20, Resident #4	•			instructions to the CNAs for resident #43 to be transferred	Ч		
	<u>-</u> 0, 1105140110	, 10010010 110 110 1			were revised to reflect the pla			
	Findings include:				care. A physician order for the			
	i mamgs merade.	е.			Temp mechanical lift was			
	1 0 - 5/24/11 - 4/	2.25 m D: 1 1/42			obtained for resident #20 and			
		2:35 p.m., Resident #43			care plan for transfer was rev			
	was observed to be transferred by CNA				to be specific and appropriate Written instructions to the CN			
		zing the "Maxi Move"			for resident #20 for transfer v			
	mechanical lift. T				revised to be specific and			
	transferred from	the bed to the			appropriate. Training with re	turn		
	wheelchair. The	resident was observed to			demonstration was conducte			
	be lifted 18 inche	es off of the mattress and			CNAs regarding how to prop	•		
	did not face the n	nast. The resident was			use the Maxi Move mechano			
		est position on the mast.			and the Tempo mechanical li Resident #59's psychologist			
	_	ned the wheelchair			contacted to provide consulta			
	The start position	ica me wheelenan			25/140tod to provide corisult	2011		

000126

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
	155221		B. WIN	IG		05/31/2	011
NAME OF	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	FROVIDER OR SUFFLIER			1120 E	AST DAVIS DRIVE		
	SARDENS HEALTH			TERRE	HAUTE, IN47802		
(X4) ID	1	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		el) and the resident was			and recommendation to the	4	
	transferred over	the side of the			resident and his MD. Reside #59's plan of care was upda		
	wheelchair. The	tipper bars of the			Lesiure service staff was	ieu.	
	wheelchair were	observed to "catch" on			inserviced on assuring safety in		
	the legs of the li	ft as the wheelchair was			the leisure service kitchen a	-	
	moved away from				on the second floor. Training	g	
	moved away no	in the nit.			content included ensuring th		
	D C.1	:.:1			drawers are always locked v		
	1	inical record of Resident			not in use and that the kitche		
	1	at 2:45 p.m. indicated the			area is safe and secure at al times, including when staff is		
	most recent Minimum Data Set (MDS) assessment was completed 4/20/11. The assessment identified the resident as				present. A process to verify	S TIOL	
					safety and security of the are	ea at	
					daily assigned intervals was		
	requiring total ca	are for transfers. The			implemented.How other resi	dents	
		t sheet for Resident #43			having the potential to be aff		
	1	ident was transferred			by the same deficient practic		
	utilizing the lift.	raciit was transferred			be identified and what correct	ctive	
	diffizing the fift.				action(s) will be taken:All residents being transferred b	N/	
	2 0 5/05/11	600 B 11 / 1/00			mechanical lift have the pote		
		6:30 a.m., Resident #20			to be affected by this deficien		
		be transferred from the			practice. All health center C		
	bed to the chair	utilizing the "Tempo"			will be retrained with return		
	mechanical lift b	by CNAs #4 and #5. The			demonstration regarding pro		
	resident was obs	erved to be lifted 18			use of the Maxi Move mecha		
	inches off of the	surface of the mattress.			lift and the Tempo mechanic		
	1	s raised to the highest			lift. Nursing management wi at least two observations on		
	1	nast. The base of the lift			shift at least two times per w		
	1 ^	r the resident was in the			for at least 4 weeks of CNAs		
	_	then moved while the			completing transfers by		
	1				mechanical lift. Deficient		
		d in the high position.			observations will be address		
		observed to tip the			through immediate retraining		
	wheelchair up of	ff of the floor and then			counseling.Residents using		
	lower the resider	nt into the seat of the			Maxi Move mechanical lift or Tempo mechanical lift will ha		
	wheelchair. The	wheelchair was then			a physician order stating the		
	lowered after the	e resident was positioned			specific type mechanical lift		
	into the seat of the	_			used in event of transfer. Th		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155221 05/31/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1120 EAST DAVIS DRIVE DAVIS GARDENS HEALTH CENTER TERRE HAUTE, IN47802 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE resident plan of care will be updated to reflect this specific On 5/25/11 at 1:15 p.m., Resident #20 order. The written instructions to was observed to be transferred from the CNAs regarding transfer by wheelchair to the bed utilizing the mechanical lift will be reflective of the physician order and care plan. "Tempo" mechanical lift by CNAs #6 and The care plan will be reviewed at #7. The resident was lifted to a position least quarterly for higher than chair seat level from the appropriateness. All residents wheelchair. The resident was moved to using the leisure service kitchen the bed in the lift and the resident did not area on the second floor have the potential to be affected by this face the mast of the lift. The resident was deficient practice. Leisure service observed to remain in the high position staff is aware of their and to be 8 inches off of the surface of the responsibility to assure that the mattress. kitchen drawers are locked when not in use and that the kitchen area is secure and safe at all Review of the clinical record of Resident times, including when staff is not #20 on 5/31/11 at 1:30 p.m. indicated the present. Safety checks of the most recent Minimum Data Set (MDS) second floor leisure service kitchen area are conducted at assessment was completed 4/25/11. The daily assigned intervals. The assessment identified the resident as Leisure Service Director or her requiring total care for transfers. The designee will conduct at least CNA assignment sheet for Resident #20 daily safety checks of the second floor leisure service kitchen area identified the resident as requiring lift for for at least 4 weeks to assure transfers. compliance. Deficient observations will be addressed Review of the manufacturer's guidelines through immediate retraining and counseling. What measures will for the "Maxi Move" mechanical lift on be put in place or what systemic 5/26/11 at 4:05 p.m. indicated "...Always changes will be made to ensure transfer patients with the chassis legs in that the deficient practice does the closed position...Before transferring, not recur: Newly hired CNAs will have a skill verfication completed position the patient to the face the regarding proper transfer attendant at approximately the height of a technique with the Maxi Move normal chair. This provides a measure of mechanical lift and the Tempo confidence and dignity to the patient..." mechanical lift. Nursing staff and rehabilitation staff will work

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/31/2011	
NAME OF PROVIDER OR SUPPLIER DAVIS GARDENS HEALTH CENTER			1120 EA	ADDRESS, CITY, STATE, ZIP CODE AST DAVIS DRIVE HAUTE, IN47802	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	for the "Tempo" 5/26/11 at 4:05 p transport the cha (closed) position with the chassis (closed) position transportation, to attendant at apprheight (see Fig. 1)	oximately normal chair 14). This gives confidence also improves the		together to assess transfer of residents requiring a mechanical lift on an ongoin basis to determine which typis most appropriate and this determination will be made according to resident's prefer for assistance; resident's most additional degree of dependency; resident's size; resident's weight-bearing ability; resident is usually cooperative status; and whether resident is usually cooperative with staff. The MDS nurse were promisted to see that mechanical lift care plans are specific and appropriate and supported by a physician or Mechanical lift care plans wireviewed at least quarterly. Scheduler will be responsible see that CNA written instruct regarding mechanical lifts are specific and reflective of the plan. Newly hired leisure senstaff orientation will include training regarding leisure service's responsibility to ensith the drawers in the leisure service is responsibility to ensith the kitchen area is safe secure at atll times, including when staff is not present. He corrective action(s) will be monitored to ensure the definition of Nursing or her designee will audit to ve that residents being transfer by mechancial lift have a spenysician order as well as spenysician order as	g pe lift rence pobility ent's enthe eve vill be e der. II The e to tions e care vice sure ervice floor and and g ow pe cient rify red ecific

000126

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/31/2011			
NAME OF PROVIDER OR SUPPLIER DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST DAVIS DRIVE TERRE HAUTE, IN47802				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	a.m., with the Micoordinator, Resas having Alzhei cognition, transformon-ambulatory. Resident #59's clareviewed on 5/24 Minimum Data Scompleted on 4/1 with minimal assambulation, utilizable mobility. The assambulation and the paymptoms direct	tour on 5/23/11 at 11:50 inimum Data Set [MDS] ident #59 was identified mer's disease, decreased erred with assistance and inical record was 4/11 at 11:25 a.m. The Set [MDS] assessment, 19/11 coded the resident sistance of one for zed a wheelchair for sessment indicated the physical behavioral ed towards others one to seven during assessment		transfer care plans and spewritten instructions to CNAs Results will be presented at Quality Assurance meeting least 3 months. Continuation audits will be dependent on outcomes. The Leisure Serv Director or her designee will to verify the second floor leservice kitchen is secure an at all times, including when is not present and that draware locked when not in use. Results will be presented at Quality Assurance meeting least 3 monhts. Continuation audits will be dependent on outcomes.	the for at on of audit ices I audit isure d safe staff ers the for at on of		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221		A. BUII	LDING	NSTRUCTION 00	(X3) DATE : COMPL 05/31/2	ETED	
		100221	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	00/01/2	
NAME OF	PROVIDER OR SUPPLIEF	2			AST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH	CENTER		1	HAUTE, IN47802		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	†	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		n a psychologist progress					
	note, dated 1/18/11 indicated the resident had history of depression, agitation,						
	1						
	paranoid ideation						
	anti-psychotic m	edication.					
	A nursing note dated 1/12/11 indicated the						
	_	nis roommate in the head					
	with a cane that	the roommate had made					
	and given him. A nursing note dated 3/23/11 at 1:30 p.m.						
	indicated the res	ident threw water on his					
	roommate as he	thought he was on fire.					
		as notified and increased					
		edication Zyprexa					
	[antipsychotic.]	one with a pro-					
	_	dated 5/13/11 at 9:30 p.m.					
		ound resident with sharp					
		Took knife found in					
	activity area that	was left out.					
	A statement, wri	tten by CNA #25 on					
	5/26/11 was prov	vided by the					
	Administrator or	n 5/27/11 at 4:05 p.m.					
	The statement by	y the CNA documented:					
	1	011 the emergency light					
	I	oom [sic] and I we [sic] to					
		nd [name] Resident #59,					
	1 ^	e kitchenette area with a					
		eak knife so I took it					
		and put it behind the					
	1	After I went through the					

l l			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155221	B. WIN			05/31/2	JII
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DV/IS C	ARDENS HEALTH (CENTED		1	AST DAVIS DRIVE HAUTE, IN47802		
					. NAUTE, IN47002		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TΕ	COMPLETION DATE
IAG			+	IAU			DATE
	was no other kniv	s [sic] to make sure there					
	was no other kniv	ves.					
	On 5/24/11 at 4:0	10 41					
	On 5/24/11 at 4:3	-					
	Administrator, DON and MDS Coordinator were interviewed. The staff						
		d not been made aware					
	of the incident.						
		. D					
		rices Director was					
		/25/11 at 2:00 p.m. The					
		icated the drawers in the					
		henette area are to be					
	-	Director indicated she					
		vers had been cleaned out					
	-	not all been locked. The					
		d knives are usually kept					
		eked cabinet. The					
	director provided						
	•	g," which documented					
		temperature checks.					
	The Director indi	icated the form also was					
	to indicate other	areas of the area were					
	kept clean, outda	ted magazines removed,					
	and cabinets lock	ted.					
	3.1-45(a)(1)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	L DIVI	DDIC	00	COMPL	ETED
		155221	A. BUII			05/31/2	011 l
			B. WIN		ADDRESS STATE STATE STATE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
D 11 // 0 0	4 DD ENG HEALTH	051755			AST DAVIS DRIVE		
DAVIS GA	ARDENS HEALTH (CENTER		IERRE	HAUTE, IN47802		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0334		evelop policies and					
SS=B	procedures that er						
	(i) Before offering the influenza immunization,						
	each resident, or t						
	•	eives education regarding					
	· ·	otential side effects of the					
	immunization; (ii) Each resident is offered an influenza						
	` '	bber 1 through March 31					
		ne immunization is medically					
		the resident has already					
		luring this time period;					
		r the resident's legal					
	representative has the opportunity to refuse						
	immunization; and	l ·					
		medical record includes					
		at indicates, at a minimum,					
	the following:						
		dent or resident's legal					
	•	s provided education					
		efits and potential side					
		a immunization; and					
	· ·	dent either received the ation or did not receive the					
		ation due to medical					
	contraindications						
	oonaamanaaaan e	or relacal.					
	The facility must d	evelop policies and					
	procedures that er						
	(i) Before offering	the pneumococcal					
	immunization, eac	th resident, or the resident's					
		e receives education					
		efits and potential side					
	effects of the immu	•					
		s offered a pneumococcal					
		ess the immunization is					
		dicated or the resident has					
	already been imm						
		r the resident's legal s the opportunity to refuse					
	immunization; and						
		medical record includes					
l	(iv) The residents	modical record molades	1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00		
		155221	B. WIN			05/31/2	011
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
DAV/IC C	ADDENC HEALTH	CENTED			AST DAVIS DRIVE		
	ARDENS HEALTH			IERRE	HAUTE, IN47802		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ГЕ	COMPLETION DATE
IAU		at indicated, at a minimum,		IAG	Dirichi.(C.)		DATE
	the following:	at indicated, at a minimum,					
		dent or resident's legal					
		s provided education					
		efits and potential side					
		coccal immunization; and					
		dent either received the munization or did not					
	1 '	nococcal immunization due					
		ndication or refusal.					
	(v) As an alternati						
	assessment and p						
	recommendation, a second pneumococcal immunization may be given after 5 years						
	following the first						
	immunization, unl						
	contraindicated or the resident or the						
		presentative refuses the					
	second immuniza		F0	224	What corrective action(s) will	lho	06/20/2011
		review and interview,	FU	334	accomplished for those resid		06/29/2011
	-	d to ensure each residents'			found to have been affected		
		ncluded documentation of			the deficient practice:Reside		
	the resident or re	_			#48, #42, #28, #32, and #25		
		eing provided information			not had any adverse effects the deficient practice. They	irom	
	1 ~ ~	enefits and potential side			and/or their responsible parti	es	
	effects of the inf				have now all received inform		
	1 *	mmunizations for 5 of 15			regarding the benefits and		
		ied receiving or offered			potential side effects of the influenza and pneumococcal		
		d/or pneumococcal			vaccinations. How other		
	immunizations in	-			residents having the potentia	ıl to	
	,	Resident #48, Resident #			be affected by the same defi	cient	
	28, Resident # 32	2 , Resident # 25)			practice will be identified and		
					what corrective action(s) will taken:All residents have the	ре	
	Findings include	::			potential to be affected by the	is	
					deficient practice. All resider		
	1. Review of the	clinical record of			and/or their responsible parti	es	
	Resident #42 on	5/27/11 at 5:30 p.m.			will receive information in wri		
					regarding the risks and bene	tits	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JU3511

Facility ID:

000126

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155221		MULTIPLE CONSTRUCTION JILDING OO O5/31/2011		TED			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST DAVIS DRIVE TERRE HAUTE, IN47802				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE .	(X5) COMPLETION DATE	
	influenza immur Documentation of made aware of the side effects of the immunization/primmunization was 2. Review of the Resident # 48 or indicated the resinfluenza immur Documentation of aware of the ben effects of the inf	reumococcal vas lacking. clinical record of 15/25/11 at 1:05 p.m. ident received the nization on 10/30/10. of the resident being made effts and potential side		of the influenza and pneumococcal vaccines prior signing the consent for administration or the declination of administration forms. All number of administration forms. All number of the inserviced regarding the proper sequence of presenting the form prior to administration declination and of the proper of the consent form. What measures will be put in place what systemic changes will be made to ensure that the defin practice does not recur: The consent for administration/declination of administration of the influenzion and pneumococcal vaccines include the wording that the information regarding the risk and benefits of the vaccines the CDC has been provided the resident and/or their responsible party in writing. Medical Records Coordinato ensure that new and correctly worded consent forms are plin admission packets and that they are available at the nurse stations. Proper completion of form for new admissions will verified by the Medical Record Coordinator at daily stand-up meeting for at least 4 weeks. Deficient outcomes will be addressed immediately and conseling. All newly hired nurse or include retraining and counseling. All newly hired nurse administration or declination or declination.	tion urses he ng on or use e or be cient a will ss from to The r will y aced at ses' f the be rds will urse on ce of		

´		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPI	
		155221	B. WINC	·		05/31/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	-	
					AST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH	CENTER		TERRE	HAUTE, IN47802		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	<u> </u>	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					of the proper use of the con form. How the corrective act will be monitored to ensure deficient practice does not recur: The Director of Nursin her designee will audit for compliance. Results will be presented at the Quality Assurance meeting for at le three months for evaluation recommendations. Continu of audits will be dependent audit outcomes.	ion(s) the g or ast and ation	
	 3 Resident #28'	s clinical record was			addit outcomes.		
	reviewed on 5/25/11 at 12:05 p.m. An						
		vas noted of, 5/6/08.					
		ndicated the resident					
		nza vaccine on 11/1/10.					
		o indicate the resident					
		family had been educated					
		ial side effects and the					
		ing immunization was					
	lacking.	mg minumzation was					
	5/26/11 at 3:05 p.m. of 4/29/10. Docume received a influenza Documentation to it resident family had potential side effect immunization was left. Resident #25'	s clinical record was					
		6/11 at 9:45 a.m. An					
	admission date w	vas noted of 1/28/11. The					
	most recent Mini	imum Data Set (MDS)					
	assessment dated	12/10/11 did not identify					
	the resident as re	ceiving the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPL	ETED
		155221	B. WIN			05/31/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	l	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	AST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH	CENTER		1	HAUTE, IN47802		
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
	influenza/pneum	ococcal vaccinations as a					
	1 ^	mented. Documentation					
	of the vaccination education information						
		ts and potential risks					
	1	o the resident or resident's					
	legal representat						
	legar representat	ive was lacking.					
	Review of the facility's current policy and						
	Review of the facility's current policy and						
	procedure titled "Influenza Vaccine" dated						
	12/07 on 5/31/11 at 2:30 p.m. indicated						
	"4. Prior to the vaccination, the resident (or resident's legal representative) or						
	1 '	*					
		e provided information					
		garding the benefits and					
	1 ^	fects of the influenza					
		on of such education					
	shall be document						
	resident's/emplo	yee's medical record"					
	Review of the fe	cility's current policy and					
	1	"Pneumococcal Vaccine"					
	1 ^	5/31/11 at 2:30 p.m.					
		•					
		Before receiving the					
	Pneumovax, the	_					
	1 -	nall receive information					
		garding the benefits and					
	1 ~	fects of the pneumococcal					
		on of such education					
	shall be docume	nted in the resident's					
	medical record						
		Director of Nursing on					
		a.m. indicated benefits of					
	the influenza and	d pneumococcal vaccines					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING D. NYNG (X3) DATE SURVE COMPLETED 05/31/2011		
		199221	B. WING		05/31/2011
	ROVIDER OR SUPPLIER		1120 EA	ADDRESS, CITY, STATE, ZIP CODE AST DAVIS DRIVE HAUTE, IN47802	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
F0368 SS=C	were not kept on residents. The Do information was and/or legal representations. 3.1-13(a) Each resident receptorize admission. 3.1-13(a) Each resident receptorize at least the times comparable community. There must be no between a substant breakfast the follow provided below. The facility must on the facility must on the substantial event following day if a remeal span, and a substantial event following day if a remeal span is a substantial event following day if a remeal span is a substantial event following day if a rem	the medical records of ON indicated the provided to the resident esentative upon eives and the facility aree meals daily, at regular to normal mealtimes in the more than 14 hours at all evening meal and wing day, except as ffer snacks at bedtime daily. If snack is provided at thours may elapse between ing meal and breakfast the esident group agrees to this nourishing snack is served. The ewant record review, to ensure bedtime and record review, to ensure bedtime ared daily for 20 of 20 in group meeting. 1, #9, #10, #18, #19, #20, 27, #31, #32, #34, #35, 50, #56]	F0368	What corrective action(s) will accomplished for those reside found to have been affected the deficient practice: Reside #2, #4, #9, #10, #18, #19, #2 #21, #23, #24, #27, #31, #32, #34, #35, #41, #42, #50, and have not experienced any adverse effects from the defi practice. How other residents have the potential to be affect by the same deficient practice be identified and what corrections.	I be 06/29/2011 dents by ents 20, 2, d #56 dicient stated the will
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155221 05/31/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1120 EAST DAVIS DRIVE DAVIS GARDENS HEALTH CENTER TERRE HAUTE, IN47802 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 1. During group meeting on 5/24/11 at 10 action(s) will be taken:All residents have the potential to be a.m., 20 of 20 residents [Residents #2, #4, affected by the deficient practice. #9, #10, #18, #19, #20, #21, #23, #24, All health center nursing #27, #31, #32, #34, #35, #41, #42, #43, staff have been trained regarding their responsibility to ensure that #50, #56] indicated snacks were not all residents are offered a snack offered on a daily basis at bedtime. The at bedtime, unless medically residents indicated snacks were provided contraindicated, regardless of only if they were requested. their asking for or their ability to ask for a snack. The offering and acceptance of bedtime snacks During interview on 5/24/11 at 9:55 a.m., will be documented by CNAs and Leisure staff person #1 indicated the this form will be reviewed by the residents in the group meeting were Director of Nursing or her interviewable. designee.10 or more random and targeted interviews and observations by mangement will During interview on 5/27/11 at 3:50 p.m., occur weekly for at least 4 weeks CNA #22 indicated dietary delivers the to ensure that bedtime snacks are being offered to all residents, snacks for bedtime and leaves them at the unless medically contraindicated, nursing station. The CNA also indicated regardless of their asking for or that if residents requested a snack then the their ability to ask for a snack would be provided. The CNA snack.What measures will be put indicated the nursing staff did not offer in place or what systemic changes will be made to ensure snacks to all residents nightly. that the deficient practice does not recur: All newly hired nursing Review of the policy and procedure titled staff will be informed during "Hydration Cart Policy and Procedure" orientation of their responsiblity to ensure that all residents are [no date] on 5/31/11 at 1:20 p.m. offered a snack at bedtime, indicated "...5. Snacks and beverages will unless medically contraindicated, be provided from the hydration cart at 7 regardless of their asking for or p.m. and at the 2 p.m. hydration cart their ability to ask for a snack.Resident council officers pass..." will be asked to include bedtime snacks being offered as a topic 3.1-21(e) for at least 3 months. In addition, resident satisfaction interviews will include whether or not

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/31/2011
	PROVIDER OR SUPPLIER		STREET A 1120 EA	ADDRESS, CITY, STATE, ZIP CODE AST DAVIS DRIVE HAUTE, IN47802	I
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0387 SS=D	The resident must least once every 3 after admission, andays thereafter. A physician visit is occurs not later the visit was required based on intervier facility failed to be in a sample of 15	be seen by a physician at 0 days for the first 90 days and at least once every 60 considered timely if it an 10 days after the date red. Every and record review, the ensure 1 of 15 residents is were seen by the tonce every 30 days for after admission.	F0387	bedtime snacks are being offered. Negative responses be reported to the administration immediately and will result in retraining and counseling. If the corrective action(s) will be monitored to ensure that the deficient practice will not recur:The Director of Nursing her designee will audit recorrelated to the offering and acceptance of bedtime snace Results will be presented at Quality Assurance meeting for least three months for evaluational recommendations. Continuation of audits will be dependent on audit outcomes dependent on audit outcomes. What corrective action(s) will accomplished for those reside the deficient practice:Reside #25 had no adverse effect found to have been affected the deficient practice. Reside #25 had no adverse effect found to have been seen by her physician and a physician progress note was complete How other residents having to potential to be affected by the same deficient practice will be same deficient practice.	s will ator in How see and attended to the see at the s
	reviewed on 5/26 admission date w	5/11 at 9:45 a.m. An vas noted of 1/28/11. The progress note on the		identified and what corrective action(s) will be taken:All residents who do not have the Medical Director for their	e

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Event ID:

JU3511

000126

Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	I			X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155221	B. WIN			05/31/2	011
NAME OF S	DROUDED OF GURDLES			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	i.		1120 EA	ST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH	CENTER		TERRE	HAUTE, IN47802		
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES	_	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	record was dated				attending MD have the poter	itial	
	10001d was dated	. 5/50/11.			to be affected by this deficier		
	Th. M. 1' 1 P	anda Dinastan			practice. The Medical Recor		
	The Medical Records Director was				Coordinator will keep a curre	nt	
		1/26/11 at 10:50 a.m. The			log of attending MD visits for		
	staff member ind	licated the physician had			resident. Attending MD will b		
	been notified by	the facility of the need			notified by phone and in writi		
	I -	its, but the resident had			when a resident is within 7 days	ays	
	1 * *	time since admission.			of not meeting State and community guidelines for		
	I -	er indicated the family			physician visit timeliness. Th	ne l	
		e need for the resident to			Medical Records Coordinato		
					notify the Medical Director if		
		nysician, but refused to let			attending MD fails to comply		
	the resident be seen by the Medical				Medical Directior will then se	e the	
	Director.				resident and complete a prog	gress	
					note within 72 hours of		
	Review of the fa	cility's current policy and			notification.What measures v		
		"Physician Services"			be put in place or what syste		
	_	-			changes will be made to ens		
		31/11 at 2:30 p.m.			that the deficient practice doe not recur: The Medical Recor		
		hysician visits, frequency			Coordinator will keep a curre		
	of visits, emerge	ncy care of residents, etc.			log of attending MD visits for		
	are provided in a	ccordance with current			resident. The resident and/o		
	OBRA regulation	ns and facility policy"			their responsible party will be		
					notified in writing by the		
	3.1-22(d)(1)				community when the residen		
	J.1 22(u)(1)				within 7 days of not meeting		
					and community guidelines fo		
					physician visit timeliness. A		
					of the notification will go to the attending MD along with his		
					her own written notification.		
					resident and/or their respons		
					party will also be notified by t		
					community in writing when/if		
					Medical Director must see th	-	
					resident and make a progres		
					note to maintain or re-establi	-	
					physician visit timeliness. Ho		
					the corrective action(s) will b	е	
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID: J	U3511	Facility II	D: 000126 If continuation sl	neet Par	ge 47 of 58

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155221	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/31/2011
	PROVIDER OR SUPPLIER ARDENS HEALTH		1120 E	ADDRESS, CITY, STATE, ZIP CODE AST DAVIS DRIVE E HAUTE, IN47802	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
				monitored to ensure the def practice does not recur:The Medical Records Coordinate audit physician visit timeline and Medical Director intevers to maintain or re-establish physician visit timeliness. It will be presented at Quality Assurance meetings for at let three months for evaluation recommendations. Continu of audits will be dependent audit outcomes.	or will ess ntion Results east and ation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING 00 COMPLETED 05/31/2011			ETED		
			B. WING	TREET AI	DDRESS, CITY, STATE, ZIP CODE		-
NAME OF I	PROVIDER OR SUPPLIER				ST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH	CENTER	т	ERRE	HAUTE, IN47802		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	Tz	AG	DEFICIENCY)		DATE
F0441 SS=E	Infection Control F a safe, sanitary an and to help prever	stablish and maintain an Program designed to provide ad comfortable environment at the development and sease and infection.					
	Program under wh (1) Investigates, coinfections in the fa (2) Decides what pisolation, should bresident; and (3) Maintains a recorrective actions (b) Preventing Spr	stablish an Infection Control nich it - ontrols, and prevents cility; procedures, such as e applied to an individual cord of incidents and related to infections.					
	determines that a prevent the spread must isolate the re (2) The facility must communicable dis lesions from direct their food, if direct disease. (3) The facility must hands after each owhich hand washin professional practice.	resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted					
		andle, store, process and as to prevent the spread of					
	Based on observa	ation, interview and	F044	1	What corrective action(s) will		06/30/2011
	record review, th	e facility failed to 1)			accomplished for those resid found to have been affected	dents d by ent ty.	
	ensure staff pract	ticed proper hand hygiene			the deficient practice:Resider		
		care for 2 of 5 residents			#46 is no longer at the facility		
observed receiving incontinence care in a				Residents #43, #19, #20, #22	2,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221		(X2) MU A. BUIL B. WING	LDING	NSTRUCTION 00	(X3) DATE: COMPL 05/31/2	ETED	
NAME OF PROVIDER OR SUPPLIER DAVIS GARDENS HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST DAVIS DRIVE TERRE HAUTE, IN47802				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	sample of 15 and observed receiving and/or personal is sample of 7 and contact isolation residents identification precauta [Residents #43, #2] [CNAs #1, #3, #3] Findings included 1. On 5/24/11 at was observed to by CNAs #1 and on was observed to by CNAs #1 and on was observed resident. Without contaminated glication into bedside table disposable wipes applied a new at removed the contaminated glication in the place of the contaminated glication in the place of the contaminated glication in the contaminated glic	13 of 5 residents ng incontinence care nygiene in a supplemental 2) ensure staff followed precautions for 1 of 1 ed utilizing contact ions in sample of 15. #19, #20, #22, #1, #46] 7, RN #17] 2: 2:35 p.m., Resident # 43 receive incontinence care #2. CNA #1 with gloves to provide pericare to t changing the oves, CNA #1 reached e drawer, picked up s, utilized the wipes, and tends. The CNA then taminated gloves. 4:35 a.m., Resident #19 receive personal hygiene A #3, with gloves on, ent's face and torso. The bserved to remove gloves se with tissue. The CNA nands in the bath water dress the resident. The		IAG	and #1 did not experience at adverse effects from the def practice. How other residen having the potential to be aff by the same deficient practice be identified and what correct action(s) will be taken:All residents have the potential affected by the deficient practice(s). All CNAs will restraining and skills verification check for peri care.All CNAs receive training and skills verification check for incontincare.All nursing staff will rectaining on glove use and changing gloves. All staff will receive training on contact isolation precautions.All staff receive training on Standard Precautions and that Standard Precautions and that Standard Precautions shall be used we caring for residents at all time regardless of their suspected confirmed infection status. A staff will receive training regarding Handwash and this training will include informing that employees must wash thier hands for at least fifteen seconds using antimicrobial soap or non-antimicrobial soap or	cicient tts rected ce will ctive to be ceive n will lence eive I f will hen es d or ll hing ust water is: ent sisting e; ntact such r	DATE

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
	155221		B. WING		05/31/2011	
NAME OF I	PROVIDER OR SUPPLIER		STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SUPPLIER		1120	EAST DAVIS DRIVE		
	ARDENS HEALTH			RE HAUTE, IN47802		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	NATE CONTINUE	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	was observed to	receive incontinence care		membranes and body fluid	I	
	by CNA #3. The	resident was observed to		excretions. The Director of Nursing or her designee wi		
	be incontinent of	Furine and bowel.		or assign infection control r	•	
	Without changin	g the contaminated		daily. Time of day will vary		
		applied a new attends on		each shift will receive 2 or		
	~	CNA then removed the		infection control rounds per	I	
				These rounds will include		
		ed the resident's bilateral		observation of staff practice		
	knee hi elastic ho	ose.		regards to peri care, incont	•	
				care, glove use, changing	Jloves,	
	4. On 5/25/11 at 5:10 a.m., Resident # 22			and Standard Precautions		
	was observed to receive incontinence care			compliance as well as cont isolation procedures when	acı	
	by CNA #3. The	resident was observed to		applicable. Deficient practi	ces	
	1	Furine. Without changing		will be addressed immedia	•	
		I gloves, the CNA was		through training and couns	•	
		•		A rounding tool will be used	- I	
	observed to apply	y a new attends.		document round results an	d	
				responses.What measures	will be	
				put in place or what system		
				changes will be made to er	•	
				that the deficient practice d	•	
				not recur:Infection control v an all-staff training topic at	•	
				every six months. New hire	icast	
				orientation for CNAs will inc	clude	
				training and skills verification	I	
				peri care and incontinence		
			1	care.New hire orientation for	I	
				nursing staff will include tra	· I	
				on glove use and changing		
				gloves.New hire orientation staff will include training on		
				contact isolation procedure	•	
				Standard Precautions, and	•	
				handwashing.Nursing		
				management will conduct of	daily	
				infection control rounds usi		
				rounding tool. Deficient pra	· I	
				will be addressed immedia	tely	
				through training and		

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE COUNSEIING. How the corrective action(s) will be monitored to ensure the deficient practice does not recur: The Director of Nursing or her designee will audit infection control training and rounds. Results will be presented at	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/31/2011				
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COUNSEIING. How the corrective action(s) will be monitored to ensure the deficient practice does not recur: The Director of Nursing or her designee will audit infection control training and rounds. Results will be presented at				1120 E	1120 EAST DAVIS DRIVE				
action(s) will be monitored to ensure the deficient practice does not recur:The Director of Nursing or her designee will audit infection control training and rounds. Results will be presented at	PREFIX (EACH DE	DEFICIENCY MUST BE PERCEDED BY FULL	REFIX (EACH DEFICIE	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE			
duality Assurance meetings of at least three months for evaluation and recommendations. Continuation of audits will be dependent on audit outcomes. 5. On 5/25/11 at 10:25 a.m., Resident #1 was observed to receive care. CNA #7 removed urine soaked incontinence briefs and slacks from the resident. Without changing gloves, the CNA assisted RN #17 to place a clean incontinence brief and slacks. RN #17, after cleansing urine from the resident's skin and without changing gloves, the RN pulled up the resident's clean brief and slacks. Review of the facility's current policy and procedure titled " Handwashing/Hand Hygiene" dated 4/2010 on 5/26/11 at 4:10 p.m. indicated "Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice.);h. Before and	5. On 5/25/ was observeremoved unand slacks: changing gill #17 to place and slacks. RN #17, afteresident's sligloves, the clean brief Review of a procedure to the procedure t	5/11 at 10:25 a.m., Resident #1 ved to receive care. CNA #7 urine soaked incontinence briefs is from the resident. Without gloves, the CNA assisted RN ce a clean incontinence brief is. Ifter cleansing urine from the skin and without changing e RN pulled up the resident's f and slacks. If the facility's current policy and titled " Handwashing/Hand dated 4/2010 on 5/26/11 at 4:10 lated "Employees must wash is for at least fifteen (15) sing antimicrobial or aicrobial soap and water under ling conditions:c. Before and et resident contact (for which lene is indicated by acceptable	5. On 5/25/11 at was observed to removed urine sand slacks from changing gloves #17 to place a cand slacks. RN #17, after claresident's skin a gloves, the RN clean brief and stacks. Review of the faprocedure titled Hygiene" dated p.m. indicated their hands for a seconds using a non-antimicrobit the following coafter direct resident hand hygiene is		action(s) will be monitored to ensure the deficient practice not recur:The Director of Nu or her designee will audit inf control training and rounds. Results will be presented at Quality Assurance meetings least three months for evaluand recommendations. Continuation of audits will be	ve o o o o o o o o o o o o o o o o o o o			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155221	A. BUILDING 05/31/2011		
		100221	B. WING	ADDRESS CITY STATE ZIR CODE	00/01/2011
NAME OF I	PROVIDER OR SUPPLIER		1	ADDRESS, CITY, STATE, ZIP CODE AST DAVIS DRIVE	
	ARDENS HEALTH			E HAUTE, IN47802	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
IAG		resident with personal	IAG		DATE
		re, bathing.);l. Upon			
	, · ·	in contact with a			
	1	skin, (e.g. when taking a			
		ressure, and lifting a			
		fter blowing or wiping			
		ntact with a resident's			
		nes and body fluids or			
	excretions;"				
	6. On 5/23/11 at 11:45 a.m. during initial				
		is observed to enter			
	Resident # 46's room to provide care to				
	the resident. The	CNA was observed to			
	enter the room w	rithout donning a gown. A			
	contact isolation	table was observed			
	outside of the res	sident's room.			
	Interview of the	MDS coordinator on tour			
	5/23/11 at 11:45	a.m. indicated Resident			
	#46 was in conta	ct isolation precautions			
	due to a recent di	iagnosis of Clostridium			
	Difficile.				
		A #23 on 5/26/11 at 11:20			
		e resident was removed			
	1	s 5/24/11. However,			
		was assigned to care for			
	resident during c				
	_	staff wore gloves to care			
		and roommate. CNA #23			
	l	sposed of gloves used for			
		ed linens in containers in			
	the resident's roo	m. The use of gowns			

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DITE	DINC	00	COMPLETED		
		155221	A. BUILDING B. WING 05/31/2011				
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					AST DAVIS DRIVE		
DV/IS C	ARDENS HEALTH	CENTED		1	HAUTE, IN47802		
	ANDENS HEALITI	CENTER		TERRE	TIAUTE, IN47 602		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	I	(5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DAT	Έ
	while caring for	Resident # 46 was not					
	indicated.						
	Interview of Res	ident #46's family on					
		a.m. indicated the staff					
		vns when assisting the					
	-	_					
		throom or providing					
	incontinence care	e for the resident.					
	Review of facilit	y's current policy and					
	procedure titled '	'Healthcare-Associated					
	Infections, Identi	ifying" dated 12/2007 on					
		.m. indicated "Standard					
	-	be used when caring for					
		mes regardless of their					
	suspected or con						
		(1) In addition to					
	wearing a gown	as outlined under					
	Standard Precaut	tions, wear a gown (clean,					
	non sterile) for a	ll interactions that may					
	involve contact v	with the resident or					
		minated items in the					
	-	nment. Remove the gown					
		_					
	•	d hygiene before leaving					
	the resident's env	ronment"					
	3.1-18(1)						
	Interview of Res	ident #46's family on					
	5/24/11 at 11:35	a.m. indicated the staff					
		vns when assisting the					
		athroom or providing					
	incontinence care	e for the resident.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
		155221			05/31/2011	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	ROVIDER OR SUPPLIER	2	l l			
DAV/10-0	ADDENO LIEALTIL	OFNITED		AST DAVIS DRIVE		
DAVIS G	ARDENS HEALTH	CENTER	TERRE	HAUTE, IN47802		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETIC	ON
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	Review of facilit	y's current policy and				
	procedure titled	"Healthcare-Associated				
	Infections, Identi	ifying" dated 12/2007 on				
	5/26/11 at 4:10 p	o.m. indicated "Standard				
	Precautions shall	be used when caring for				
		mes regardless of their				
	suspected or con	· ·				
	-	(1) In addition to				
		as outlined under				
		tions, wear a gown (clean,				
	· · · · · · · · · · · · · · · · · · ·	ll interactions that may				
		with the resident or				
	•	minated items in the				
	resident's environ	nment. Remove the gown				
	and perform han	d hygiene before leaving				
	the resident's env	vironment"				
	3.1-18(1)					
	()					
R0000						
	The following st	ate residential findings	R0000	By submitting this document		
	were cited in acc	cordance with 410 IAC		are not admitting the truth of		
	16.2-5.			accuracy of any specific find		
	10.2 0.			or allegations. This submiss made solely pursuant to our		
				regulatory obligations.		
				Togulatory obligations.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JU3511

Facility ID:

000126

If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155221		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE: COMPL 05/31/2	ETED	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST DAVIS DRIVE				
DAVIS G	ARDENS HEALTH	CENTER		TERRE	HAUTE, IN47802		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ.	(X5) COMPLETION DATE
R0090	(g) The administration overall management responsibilities of include, but are not (1) Informing the coccurrence that disafety, or health ounusual occurrence telephone, followed written report only electronic mail to the twenty-four (24) hooccurrences include (A) epidemic outbin (B) poisonings; (C) fires; or (D) major accident If the division cannot be made to the enpublished by the coccurrence or other telephone, followed written report only electronic mail to the twenty-four (24) hooccurrences include (A) epidemic outbin (B) poisonings; (C) fires; or (D) major accident If the division cannot be made to the enpublished by the coccurrence or other telephone, followed with the division of medical nursing care or other telephone, followed with the enpublished by the coccurrence in the division of medical nursing care or other telephone, followed with the enpublished by the coccurrence in the division of medical nursing care or other telephone, followed with the enpublished by the coccurrence in the division cannot be made to the enpublished by the coccurrence in the division cannot be made to the enpublished by the coccurrence in the division cannot be made to the enpublished by the coccurrence in the division cannot be made to the enpublished by the coccurrence in the division cannot be made to the enpublished by the coccurrence in the division cannot be made to the enpublished by the coccurrence in the coccurrence	tor is responsible for the ent of the facility. The the administrator shall of limited to, the following: livision within twenty-four ming aware of an unusual rectly threatens the welfare, of a resident. Notice of the may be made by do by a written report, or by a that is faxed or sent by the division within the four time period. Unusual de, but are not limited to: reaks; Is. In the reached, a call shall the regency telephone number in itsion. It is ging for or assisting with the all, dental, podiatry, or the health care services as the esident or resident's legal extor approval prior to the dividual under eighteen (18) adult facility. It is according to the reached of actual time the test the: In name; and resources worked during the past					

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155221		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/31/2011	
NAME OF PROVIDER OR SUPPLIER DAVIS GARDENS HEALTH CENTER				1120 E	ADDRESS, CITY, STATE, ZIP CODE AST DAVIS DRIVE HAUTE, IN47802	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	by the division in two (2) years and for inspection to a upon request Based on interview failed to inform the Department of Heal of 1 occurrence of r of 4. Finding includes: On 5/25/11 at 2:15 provided a form titl Form," which docur occurred 2/10/11 at documentation of R apartment and went near entrance under staff. The date on titl Department of Heal March 9, 2011. A report of an invest provided by the MI Coordinator on 5/25 was not limited to: resident. Found out 2nd canopy waved light jacket on (3 deshe didn't make sen gave him some "key radio. They were n were-she could not Two reports of Coudated 3/8/11 and 3/9 Administrator, and	ports of surveys conducted each facility for a period of making the reports available my member of the public and record review, the facility Administrator and report to the th within twenty-four hours 1 esident elopement in a sample p.m. the Administrator ed "Facility Incident Reporting mented an incident that 1:50 a.m. The report included esident #4 leaving her outside and stood on sidewalk the canopy without telling he report form of the th being notified was noted of tigation of the incident, DS [Minimum Data Set] 5/11 at 2:15 p.m. included, but "2/10/11 at 1:50 a.m. confused eside by Security Guard, under eat him. Was dressed and had egrees) outside. Security said see-something about her car, ys" and he called nurse on out car keys-she thought they get back in building." Inseling/Disciplinary Actions, D/11, completed by the provided by the DON on indicated LPN #26 received a	RO	0090	What corrective action(s) will accomplished for those reside found to have been affected the deficient practice:Reside suffered no injury as a result the incident. Family and MD notified. MD ordered lab wo routine ambien order was changed to administer a needed, frequent checks initiated. How other residents having the potential to be affected by the same deficient practic be identified and what correct actions(s) will be taken: All residents with mild or greate mental confusion and/or impairment are at risk to be affected by this deficient practice. All staff will be trained the State and community requirement that the Administrator be informed immediately of resident elopement and that the Department of Health be not by the Administrator or his designee within 24 hours of elopement occurring. Daily stand-up will include review incidents and unusual occurrences, including elopements. What measures be put in place or what systechanges will be made to ensuthat the deficient practice do	dents by ent #4 c of o were rk; as fected be will ctive r ed on diffied the of will emic sure	05/31/2011

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/07/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155221		(X2) MULTIPLE CO A. BUILDING	00	(X3) DATE SURVEY COMPLETED			
		155221	B. WING		05/31/2011		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 EAST DAVIS DRIVE TERRE HAUTE, IN47802				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	during the night shift outside and the DON facility rules in that made aware of the outside and the DON facility rules in that made aware of the outside aware of the outside aware of the Adrip.m. indicated he was until 3/9/11. Review of facility's titled "Reportable U 1/25/2006 on indicated that all alleged violate neglect, or abuse, in source and misapproare reported immedithe facility and to otwith State law throut (including to the State AgencyABUSE-presental (known and/Elopement- a cognit was found outside the whereabouts had been sometimed to the shade of the state of the shade of the sh	not reporting to the DON fit the resident being found N was found in violation of the the Administrator was not occurrence until 3/8/11. ministrator on 5/25/11 at 2:30 as unaware of the elopement current policy and procedure finusual Occurrences" dated ted "the facility must ensure tions involving mistreatment, cluding injuries of unknown opriation of resident property lately to the administrator of ther officials in accordance agh established procedures the Survey and Certification oblysical, sexual, verbal and/or for alleged)Resident tively impaired resident who me facility and whose en unknown, Any perment which required police		not recur:New hire orientatic include training that the Stat community requires that the Administrator be informed immediately of resident elopement and that the Department of Health be not by the Administrator or his designee within 24 hours of elopement occurring.Daily stand-up meeting will including elopements. The administration his designee will monitor for events that meet State reportive and will address any non-compliance immediately training and counseling that include termination. How the corrective action(s) will be monitored to ensure the definition practice will not recur: The Administrator will audit even reportable to State, including elopements. Results will be reported at the Quality Assumeeting for at least three months. Continuation of audit outcomes.	e and iffied e sual or or rtable / with may cient ts g		